Meeting Date	**23 February 2021**	**Agenda Item**	**4.4**
Report Title	**Maternity Service Assurance paper**		
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Report Sponsor	Lesley Jenkins, Group Nurse Director		
Presented by	Susan Jose, Interim Head of Midwifery		
Freedom of Information	Open		
Purpose of the Report	This paper will provide the Quality and Safety Committee an update on assurance of the maternity service position in relation to achievement and actions required in line with the Welsh Government document "Maternity Care in Wales. A Five Year Vision for the Future (2019-2024) July 2019".		
Key Issues	Following publication of the Welsh Government document "Maternity Care in Wales. A Five Year Vision for the Future (2019-2024). July 2019", significant national and local reports have been published for maternity services to benchmark and make improvement to the quality and safety of maternity care provided in the health board. The relevant reports have been attached as appendix to this paper. An overarching action plan to address the themes of all the attached reports is in development. The five themes of the maternity Vision Document (2019) is being utilised as a framework. 1. Family centred care 2. Safe and effective care 3. Continuity of carer 4. Skilled multi-professional teams 5. Sustainable quality services The action plan will be a working document toward service improvement and will evidence the quality, safety and performance of the maternity service.		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☒	☒	☐

Recommendations	Members are asked to: • **CONSIDER** **Items for information will not be allocated time for consideration within the Board/Committee meeting.**

Maternity Service Assurance report

1. INTRODUCTION

This report is an assurance paper requested by the Quality and Safety Committee in relation to Swansea Bay University Health Board maternity services. The report presents the key issues within the maternity service using the five themes of the Welsh Government document "Maternity Care in Wales. A Five Year Vision for the Future (2019-2024). July 2019" (Maternity Vision) as a framework:

1. Family centred care
2. Safe and effective care
3. Continuity of carer
4. Skilled multi-professional teams
5. Sustainable quality services

2. BACKGROUND

The Maternity Vision sets out the 5 year strategy of the Welsh Government towards the improvement of maternity services in Wales.

Immediately prior to the publication of the Maternity Vision the report into the maternity services at Cwm Taf University Health Board was published (RCOG/RCM 2019). The findings of the report were so significant that Healthcare Inspectorate Wales (HIW) commenced a wide ranging review of maternity services in Wales.

The reports relating to Swansea Bay Health Board's unannounced HIW inspections (2019a, 2019b), as well as the national Phase One thematic report (2020) have been attached as appendices.

In December 2020 further national reports were published requiring maternity services to further benchmark against report recommendations;

- a report into a failing maternity service "Emerging Findings and Recommendations from the Independent Review of maternity services at the Shrewsbury and Telford Hospital NHS Trust" (Ockenden 2020)
- the triennial report of Mothers and Babies: Reducing Risk through audits and confidential enquiries across the UK (MBRRACE)
- the annual MBRRACE perinatal report and a special report in relation to multiple pregnancy care.
- In January 2021 the initial report of the Independent Maternity Services Oversight Panel (IMSOP) for Cwm Taf Morgannwg University Health Board was published.

Themes emerged within the recommendations of the multiple reports that will be supported by the Maternity Network and all Wales Heads of Midwifery with a "Once for Wales" approach, with work planned to commence in February 2021.

Swansea Bay University Health Board maternity service leads are developing an overarching action plan to work through the recommendations from the individual reports, with identified service improvement where required. All national and local

work will be completed using the Maternity Vision document as a framework of achievement and assurance for Welsh Government Performance Board.

3. GOVERNANCE AND RISK ISSUES

1. Family centred care: Women will receive personalised care, planned in partnership with them and reflecting their choices and health needs

A theme identified throughout the reports is that women do not feel listened to. The Consultant Midwife in partnership with service leads and the strategy and planning team, is developing a women's engagement strategy for the next 5 years. This will provide a detailed plan for the introduction of the "Maternity Voices Partnership" (MVP), for effective service user partnership working. The MVP is an initiative that has evaluated well in England. It will replace the Maternity Service Liaison Committee (MSLC) and will modernise how women engage with the service and how service is designed and delivered with women at the centre.

We have introduced the telling of a patient story at all key maternity service meetings which are an essential component of learning. The service needs to ensure team members are appropriately trained for this role to ensure women have the opportunity to share their story with us.

The service continues to engage with the health board feedback programme.

2. Safe and effective care: Women will receive safe and effective care; with risk, intervention and variation reduced wherever possible.

The maternity service leads are fully engaged with the national work being coordinated by the all Wales Maternity and Neonatal Network and the all Wales Heads of Midwifery Group (HoMag). Work streams within the all Wales groups are aligned to the Maternity Vision, with a current focus on thematic learning from the many reports received by the maternity service.

2020 has shown an increase in the health board stillbirth rate, from 3.9 per 1000 in 2019 to 5.4 per 1000 in 2020. A high level review of cases was undertaken for any themes identified from care provision. A number of factors were highlighted; perinatal mental health issues, increased BMI, smoking and small for gestational age foetus.

11 of the 16 stillbirths showed women had more than one of the identified risk factors. Actions taken in response to the increase in stillbirth rate and identified themes include;

- A midwife given a development opportunity to undertake focus groups with maternity staff on management of women who present with multiple risk factors. The work is coming to a conclusion and will report to the maternity quality and safety group in March with recommendations for practice and information giving.
- The health board remains non-compliant with the provision of the perinatal institute Growth Assessment Programme (GAP). Two midwives have been funded to complete ultrasound training in 2021 in order to increase the provision and capacity of the ultrasound service for women. The maternity

service will work with the Delivery unit to fully develop the governance and monitoring of the service prior to expansion for sustainability.

- The Public Health midwife is linked with the Public Health Wales leads for smoking cessation. All women are automatically referred to the help me Quit service at booking. All in-patient areas in the hospital are able to support and offer Nicotine Replacement Therapy (NRT). Due to the Covid pandemic the use of Co monitors are currently on hold. This is a key tool for supporting women to stop smoking and Welsh Government has been asked for an update on re-introduction. Further work is required to ensure midwives evidence the conversations they have with women in support of smoking cessation throughout pregnancy.
- The service does not currently employ a full time perinatal mental health midwife. Due to the Mother and baby Unit being located in Swansea Bay UHB and a small allocation of specialist midwifery budget and advert will shortly be placed for 0.4wte (15 hours) role. There may be an opportunity from external funding to increase by 0.5 (18.75hrs), which is currently being explored. This will ensure a full time specialist perinatal mental health midwife who will develop the service as appropriate.

The maternity service governance structure and resource is currently under review led by the Group Nurse Director. This is an outstanding action from the action plan in relation to the RCOG/RCM Cwm Taf report (2019). The current structure and resource impacts on the service ability to manage serious incident investigation reporting in a timely way.

The perinatal mortality review tool (MBRRACE reporting), is embedded in the unit process and the service is working with the maternity and neonatal network toward the introduction of external validation of all stillbirth reviews

3. Continuity of carer: Women will experience continuity of carer across the whole of their maternity journey

Throughout 2020 and the Covid pandemic continuity of carer has been fragmented. This has been primarily due to staffing levels. The altered Covid care pathways to provide essential face to face visits only has impacted by reduced flexibility within the workforce. The Continuity of carer will form the cornerstone of the maternity service recovery plan from Covid restrictions and will include both midwifery led and obstetric led care pathways.

4. Skilled multi-professional teams: Women will receive care from multi-professional teams, with access to specialist services

Practical Obstetric multi-professional training (PROMPT) is embedded into the unit with training being provided throughout the pandemic. Community PROMPT will be introduced later in 2021. Foetal surveillance training and reflection is provided weekly with the formal study day update provided monthly. The Training and Education Group monitor compliance and report on an annual basis.

Throughout the pandemic all other face to face training was discontinued. The Training and Education Group are currently planning the recovery of training within the maternity service

Two midwives are currently attending the University West of England ultrasound course to improve capacity and sustainability of the ultrasound service.

5. Sustainable quality services: Women will receive maternity services which are sustainable and the highest quality possible

The health board is Birthrate + compliant in relation to the midwifery workforce. Key appointments to be made include a clinical governance lead midwife, a perinatal mental health midwife, Public health midwife, and midwife sonographer roles on successful completion of the ultrasound course.

The Obstetric workforce provides in excess of the 60 hours per week labour ward cover in line with RCOG standards. Two Obstetric Consultant vacancies are currently being advertised to maintain the position.

A review of the obstetric antenatal clinics is currently in-train to organise services within defined care pathways as recommended best practice.

The procurement procedure for the foetal surveillance central monitoring system for Singleton Hospital has been completed with the preferred provider chosen. Work will progress during 2021 to install the system. A foetal surveillance lead for midwifery and obstetrics work in partnership to upskill the maternity team on foetal surveillance education and training and will be instrumental in training provision for the new way of care giving utilising a central monitoring system.

4. FINANCIAL IMPLICATIONS

This paper is submitted to provide an overview and assurance to the Quality and Safety Committee for the maternity service. The financial implications are undetermined at this time and business cases will be prepared for funding streams as appropriate

5. RECOMMENDATION

The committee is asked to note the actions being taken within Maternity Services to ensure compliance with recommendations from local and national reports, and the Maternity Vision.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

Quality, Safety and Patient Experience

The actions being taken will improve quality, safety and patient experience.

Financial Implications

There are no specific financial implications relating to this paper, though some of the actions required may have associated costs which will be dealt with appropriately at the relevant time

Legal Implications (including equality and diversity assessment)

There are no known legal implications related to this, nor is there a negative impact on equality or diversity.

Staffing Implications

There are no specific staffing implications relating to this paper, though some of the actions required may have workforce implications which will be dealt with appropriately at the relevant time.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

Briefly identify how the paper will have an impact of the "The Well-being of Future Generations (Wales) Act 2015, 5 ways of working.

- **Long Term** - The culture of continuous improvement and assurance within Maternity Services will lead to long term health benefits for the population by delivering excellent care for mothers and babies.

○ **Prevention** – An improved focus on improving maternal health and reducing risk factors such as smoking and obesity will contribute to the reduction of harm caused by pre-term/ low weight babies. ○ **Integration –** The service works closely with colleagues in public health, health visiting and mental health services. ○ **Collaboration -** The service works closely with colleagues in public health, health visiting and mental health services. ○ **Involvement –** the development of the Maternity Voices Partnership will ensure that women and families are involved in improving services in ways which meet their holistic needs.	
Report History	 2019-10-11-Quality Safety Maternity GAP  2019-09-27-submission for Quality and Safe  2020-03-ultrasound scan capacity and der
Appendices	Appendix 1, 2 and 3.